# DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

## APPLICATION FOR CERTIFICATION TO PROVIDE LIMITED SERVICES TO AN INDIVIDUAL UNDER THE SELF-ADMINISTERED SERVICES

Name of Applicant: _____ Date: _____

Address: _____ Phone: _____

Name of Person Applicant Desires to Support: _____

Service(s) Applicant Desires to Provide (*Circle All Applicable Services):***CH 1; FS1; FTP; HS1; LKS; PAC; RP1 (Q); RP1 (D); SLA;.**

**Knowledge Requirements for Certification:**

| | | |
|---|---|---|
| Employment Agreement | ☐ | Date _____ |
| Department of Human Services Provider Code of Conduct | ☐ | Date _____ |
| Division of Services for People With Disabilities' (Division) Code of Conduct | ☐ | Date _____ |
| Emergency Contact Information | ☐ | Date _____ |
| Person's Support Book | ☐ | Date: _____ |
| Behavior Management (if applicable) | ☐ | Date _____ |

**SIGNATURES:**

**I represent that I have read and am familiar with the above-identified materials and that I have been oriented to and/or trained on all of the materials by: _____on the dates indicated. I further represent that I both understand and will comply with the requirements identified in the materials in providing services to the Person and that I am capable of providing appropriate services to the Person.**

_____ _____

Signature of Applicant Date

**I, _____ represent that I am the Person, the Person's Representative, or the Person with a Designated Administrator of Supports for the Person and that I am familiar with both the above-identified materials and the supports required by the Person. I further represent that I provided orientation and/or training to the Applicant on all of the required materials on the dates indicated. I further represent that based on the training and orientation provided to the Applicant, I am satisfied the Applicant has the knowledge, understanding, and ability to provide appropriate services to the Person.**

_____ _____

**Signature of Person, Guardian, or Designated Administrator** Date

**AWARD OF CERTIFICATION TO PROVIDE LIMITED SERVICES TO AN INDIVIDUAL WITH MENTAL RETARDATION OR RELATED CONDITION RECEIVING SELF-ADMINISTERED SERVICES**

Based on the forgoing representations of the Applicant and the Person, Person's Legal Guardian, or Person's Designated Administrator of Supports, the Applicant has met the minimum requirements necessary for Certification to Provide Limited Services to an Individual receiving Self-Administered Services. The Division, therefore, awards the Applicant certification to provide the following services *(circle those applicable)*:
**CH 1; FS1; FTP; HS1; RP1 (Q); RP1 (D); SLA.** to :_____.

**(Name of Person)**

_____ _____

Signature of Division Support Coordinator Date